REDACTED

BEFORE THE DIVISION OF MEDICAL QUALITY

BOARD OF MEDICAL QUALITY ASSURANCE

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against: BEN THOMPSON, M.D. 5050 Brockton Avenue Riverside, California Physician's and Surgeon's Certificate No. 20A-1023 Respondent.	NO. D-1841 L-12488

DECISION

This matter came on regularly for hearing pursuant to notice duly given before the Division of Medical Quality, the undersigned five members of which were present and acting throughout the proceeding, at San Diego, California, on October 25, 1976, at the hour of 11:00 a.m. and was heard on that day and on the successive days following until it was concluded on October 29, 1976. Mark A. Levin, Deputy Attorney General, appeared on behalf of the complainant. Respondent was present in person and was represented by Tim S. Thomas of the San Diego Bar. Oral and documentary evidence was introduced by the parties. The Division finds the following facts:

I

Raymond M. Reid was the Executive Officer of the Board of Medical Quality Assurance of the State of California and made and filed the Accusation herein in his official capacity.

II

Respondent Ben B. Thompson, M.D., has been licensed in the State of California as a physician and surgeon since on or about July 11, 1941. The physician's and surgeon's certificate number of respondent is 20A-1023. On or about July 3, 1975

respondent's certificate was disciplined by the Board of Medical Examiners, State of California. Pursuant to said disciplinary order the certificate of respondent has been suspended in the State of California at all times since December 1, 1975, with said suspension to remain in effect through November 30, 1976.

III

On or about August 24, 1975 respondent performed an augmentation mammaplasty on P[redacted] R[redacted] at a facility known as La Gloria Hospital in Rosarita Beach, Baja. California. Respondent permitted Luis Salas to participate in said surgical procedure. It was not established that several days before this procedure R[redacted] had specifically informed respondent that she did not want Salas to participate in said surgical procedure. Evidence does not establish that respondent assured Reece that he would be assisted by a qualified plastic surgeon.

Following the augmentation mammaplasty R[redacted] was placed in a room in said La Gloria Hospital which she shared with another patient. She was unable to communicate with the available staff during the night of August 24, 1975 following her surgery, as the members of said staff did not have command of the English language. Although she felt hunger and pain R[redacted] was unable to obtain assistance as a result of the staff arrangement and the language problem.

On or about the evening of August 24, 1975 R[redacted] fell to the floor at La Gloria Hospital, sustaining an injury to her head which was accompanied by bleeding. She was left in her bed while she continued to bleed from her head. R[redacted] was unable to obtain a change of her blood-soaked linen until she offered to pay a member of the staff a dollar for such service. When she requested that respondent be summoned to assist her, R[redacted] was informed that he was not available. She was permitted to continue to bleed for a period of several hours.

On or about the morning of August 25, 1975, the following day, respondent returned to R[redacted] room. After observing that R[redacted] had sustained a head injury, respondent had her returned to the operating room for a surgical procedure commonly referred to as a facelift. Respondent permitted Salas to participate in said surgical procedure. When R[redacted] awakened later on August 25, 1975 following said facelift operation, respondent informed her that they were returning to the United States. Respondent and another man assisted R[redacted] down a stairway to respondent's motor home and R[redacted] was transported to an apartment building in Riverside, California, part of which was utilized by respondent as a recovery facility for his patients. R[redacted] remained at said apartment building for one day. It was not established that R[redacted] was unable to obtain assistance in acquiring food or medical care while at said apartment building.

On or about August 28, 1975 R[redacted] contacted respondent's office to arrange for the removal of stitches from the area around her eyes. Respondent was in Palm Springs and when reached by R[redacted], gave R[redacted] the alternative of going to Tijuana to have Salas remove the stitches. R[redacted] followed the instruction of respondent and said stitches were removed by Salas.

On or about September 4, 1975 R[redacted] telephoned respondent to make arrangements for the removal of stitches from the inside of her face. Respondent told R[redacted] he would be available in Riverside but she was then unable to travel there. Respondent instructed her to go to his Point Loma office on September 5, 1975 where respondent would have a doctor present to remove the stitches. On said date R[redacted] went to the Point Loma office of respondent at the appointment time and found no physician present. One of the women working at the office removed the stitches.

On or about September 6, 1975 R[redacted] detected the symptoms of infection in her right breast. On or about September 8,

1975 R[redacted] went to respondent's Point Loma office for treatment for said infection at which time she was instructed by a physician on the premises to see respondent in Mexico. On or about September 9, 1975 R[redacted] went to Rosarita Beach, where respondent looked at her breast and prescribed an antibiotic, Erythromycin. No further examination or treatment was conducted or rendered by respondent on that occasion.

On or about September 14, 1975 the aforementioned infection began to drain and R[redacted] called respondent who agreed to see her at his Riverside office on September 15, 1975. R[redacted] arrived at respondent's Riverside office shortly after the appointed hour and was directed to wait at the aforementioned apartment building. She waited for several hours and finally left, respondent never having appeared.

On or about October 1, 1975 R[redacted] saw respondent for the last time at his Point Loma office. Her right breast was still draining but respondent prescribed no more medication.

R[redacted]s infection had progressed to the point that her health was significantly impaired, resulting in the surgical removal of the prosthesis from her right breast on or about October 10, 1975 by another physician. R[redacted] continued to have difficulty with the infection and the second surgery by the same physician on or about November 7, 1975 resulted in the removal of a sponge which had been left in the operative site during the placement of the right implant by respondent on August 24, 1975.

IV

Pursuant to disciplinary order in Case No. D-1511 of the Board of Medical Examiners, the physician's and surgeon's certificate of respondent had been suspended at all times since December 1, 1975 and will continue under suspension through November 30, 1976.

On or about December 14, 1975 respondent conducted a medical examination upon M[redacted] H[redacted] at his office in Riverside, California. Respondent had previously performed an augmentation

mammaplasty upon H[redacted] on or about September 22, 1975 at Rosarita Beach. On or about December 14, 1975 respondent, following said examination, surgically removed an implant from H[redacted]s left breast at respondent's Riverside office. Said procedure was performed by respondent alone and with the use of local anesthesia.

In or about the middle of January, 1976 respondent conducted a medical examination of H[redacted]s left breast at his Riverside office. Following said examination respondent prescribed medical treatment for H[redacted] by ordering a member of his staff to apply ointment to H[redacted]s left breast at said time.

Pursuant to condition (1) of the probation of respondent included in the disciplinary order in Case No. D-1511 of the Board of Medical Examiners, respondent was suspended from the practice of medicine for one year and was thereby prohibited from exercising any of the privileges granted to him under his physician's and surgeon's certificate. Said period of suspension commenced on December 1, 1975.

* * * * *

Pursuant to the foregoing findings of fact, the Division makes the following determination of issues:

I

Gross negligence constitutes unprofessional conduct pursuant to the provisions of Section 2361(b), Business and Professions Code of California.

II

Respondent is guilty of unprofessional conduct in that he provided grossly negligent medical treatment to P[redacted] R[redacted] in August and September 1975 in the following respects:

1. Respondent's selection of La Gloria Hospital as a surgical and postoperative facility constitutes an extreme departure from the standards of medical

care.

2. Respondent's postoperative unavailability and his failure to provide comparable medical coverage constitutes an extreme departure from the standard of medical care in that respondent should have recognized that Reece could develop an infection.

3. It was not established that respondent's permitting of Salas to participate in R[redacted] surgery was contrary to R[redacted] announced wishes.

4. Respondent's performance of the second surgery (facelift) one day following the augmentation mammaplasty while he knew or should have known of R[redacted]s physical and emotional condition constitutes inhumane treatment and an extreme departure from the standards of medical care.

III

Incompetence constitutes unprofessional conduct pursuant to the provisions of Section 2361(c), Business and Professions Code of California.

IV

Respondent is guilty of unprofessional conduct in that he provided incompetent medical treatment to R[redacted] R[redacted] in August and September of 1975 in the following respects:

1. Respondent's selection of La Gloria Hospital as a surgical and postoperative facility constitutes incompetence in the practice of medicine.

2. Respondent's postoperative unavailability and his failure to provide comparable medical coverage constitute incompetence in the practice of medicine in that respondent should have recognized

that R[redacted] could develop an infection.

3. It was not established that respondent's permitting of Salas to participate in R[redacted]s surgeries was contrary to R[redacted]s announced wishes.

4. Respondent's performance of the second surgery (facelift) one day following the augmentation mammaplasty, while he knew or should have known of R[redacted]s physical and emotional condition constitutes inhumane treatment and incompetence in the practice of medicine.

V

Respondent practiced medicine in California on at least two occasions (December 14, 1975 and January 6, 1976) concerning M[redacted] H[redacted] while he was under disciplinary order of suspension of his physician's and surgeon's certificate and in violation of condition (1) of his probationary order. His certificate shall be revoked pursuant to the provisions of Section 2373, Business and Professions Code of California.

VI

The Division shall take action against any holder of a certificate who is guilty of unprofessional conduct pursuant to the provisions of Section 2361, Business and Professions Code of California, in accordance with Sections 2360 and 2372 of said Code.

* * * * *

WHEREFORE, the Division of Medical Quality makes the following order:

1. The stay of the order of revocation contained in the order of the Board of Medical Examiners in Case No. D-1511 effective December 1, 1975 is now set aside and the revocation is ordered to become effective for breach of condition (1) of the probationary order therein (practicing while license suspended),

and said probation is terminated.

2. The physician's and surgeon's certificate No. 20A-1023 of Ben Thompson, M.D., is revoked for the determined unprofessional conduct of gross negligence.

3. ~~The physician's and surgeon's certificate No. 20A-1023 of Ben Thompson, M.D., is revoked for the determined unprofessional conduct of incompetence.~~

4. All portions of this order shall become effective November 30, 1976.

* * * * *

IT IS SO ORDERED this 18 day of Nov., 1976.

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

BY Eugene C. Feldman M.D.
EUGENE C. FELDMAN, M.D. President

Blanche C. Bersch
BLANCHE C. BERSCH, Secretary-Treasurer

James Lockhart
JAMES LOCKHART, M.D., Member

MICHAEL L. GREER, Member

Margaret Castro
MARGARET M. CASTRO, Member

WG:mh

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Attorneys for Complainant

BEFORE THE DIVISION OF MEDICAL QUALITY

BOARD OF MEDICAL QUALITY ASSURANCE

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against: BEN THOMPSON, M.D. 5050 Brockton Avenue Riverside, California Physician's and Surgeon's Certificate No. 20A-1023, Respondent.	NO. D-1841 ACCUSATION AND PETITION TO REVOKE PROBATION

Complainant, RAYMOND M. REID, alleges as causes for disciplinary action against the above named and captioned respondent, as follows:

1. He is the Executive Officer of the Board of Medical Quality Assurance of the State of California (hereinafter referred to as the "Board") and makes and files this Accusation solely in his official capacity.

2. Respondent Ben B. Thompson, M.D. (hereinafter "respondent") has been licensed in the State of California as a physician and surgeon since on or about July 11, 1941. Respondent's physician's and surgeon's certificate number is 20A-1023. On or about July 3, 1975, respondent's certificate

was disciplined by the Board of Medical Examiners of the State of California; a true and correct copy of said disciplinary order is attached hereto and incorporated hereat as Exhibit "A." Pursuant to said disciplinary order, respondent has been suspended from practicing medicine in the State of California at all times since December 1, 1975; said suspension shall remain in effect through November 30, 1976.

3. Pursuant to section 2100 of the Business and Professions Code,[1/] there exists a Board of Medical Quality Assurance of the State of California, as successor to the Board of Medical Examiners.

4. Pursuant to section 2100.5, there is a Division of Medical Quality within the Board of Medical Quality Assurance (hereinafter the "Division").

5. Pursuant to section 2100.6, the Division is responsible, inter alia, for the administration and hearing of disciplinary actions and the carrying out of disciplinary action appropriate to findings made by a Medical Quality Review Committee or a Hearing Officer (Administrative Law Judge).

6. Pursuant to sections 2360 and 2372, the Division shall take disciplinary action against any holder of a physician's and surgeon's certificate who is guilty of unprofessional conduct.

7. Gross negligence constitutes unprofessional conduct pursuant to section 2361(b).

8. Respondent is guilty of unprofessional conduct within the meaning of section 2361(b) in that he provided grossly negligent medical treatment to Patricia R[redacted] in August and September of 1975, as more particularly alleged hereinafter:

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1. All statutory references are to the Business and Professions Code unless otherwise specified.

A. On or about August 24, 1975, respondent performed an augmentation mammaplasty on Patricia R[redacted] (hereinafter "R[redacted]") at a facility known as La Gloria Hospital in Rosarita Beach, Baja, California. Respondent permitted Luis Salas (hereinafter "Salas") to participate in said surgical procedure. Several days before this procedure, R[redacted] had specifically informed respondent that she did not want Salas to participate in said surgical procedure and respondent assured R[redacted] that he would be assisted by a qualified plastic surgeon.

B. Following the reduction mammaplasty, R[redacted] was placed in a room in said La Gloria Hospital which she shared with another patient. She was unable to communicate with the attending staff following surgery as the members of said staff did not have command of the English language. Although she was hungry and in pain, R[redacted] was unable to summon assistance as a result of the inadequate staff and the language problem.

C. On or about the evening of August 24, 1975, R[redacted] fell to the floor at La Gloria Hospital, sustaining an injury to her head which was accompanied by heavy bleeding. She was left in her bed while she continued to bleed from her head. R[redacted] was unable to obtain a change of her blood-soaked linen until she offered to pay a member of the staff a dollar for such service. When she requested that respondent be summoned to assist her, R[redacted] was informed that he was not available. She was permitted to continue to bleed for a period of several hours.

D. On or about the morning of August 25, 1975, the following day, respondent returned to R[redacted]'s room. After observing that R[redacted] had sustained a head injury, respondent had her returned to the operating room for a surgical procedure commonly referred to as a face lift. Respondent permitted Salas to participate in said surgical procedure. When R[redacted] awakened later, on August 25, 1975, following said face lift operation, respondent informed her that he was returning to the United States. When R[redacted] requested not to be left at the La Gloria facility, respondent and another man partially dragged R[redacted] down a stairway to respondent's motor home and transported R[redacted] to an apartment building in Riverside, California, owned and/or operated by respondent.

E. R[redacted] remained at said apartment building for one day. R[redacted] was unable to obtain assistance in obtaining food or medical care while at said apartment building.

F. On or about August 28, 1975, R[redacted] contacted respondent's office to arrange for the removal of stitches from the area around her eyes. Respondent was in Palm Springs and when reached by R[redacted], told R[redacted] to go to Tijuana and have Salas remove the stitches. R[redacted] followed respondent's instructions and said stitches were removed by Salas.

G. On or about September 3, 1975, R[redacted] called respondent to make arrangements for the removal of stitches from the side of her face.

Respondent told R[redacted] he would be unavailable as he would be in Palm Springs and instructed her to go to his Point Loma office on a date certain, on or about September 5, 1975, and that respondent would have a doctor there to remove the stitches. On said prearranged date, R[redacted] went to respondent's Point Loma office at the appointment time and found no physician present. One of the women working at respondent's office removed the stitches.

H. On or about September 13, 1975, R[redacted] detected the symptoms of infection in her left breast. On or about September 15, 1975, R[redacted] went to respondent's Point Loma office for treatment of said infection at which time she was instructed by a physician on the premises to see respondent in Mexico. On or about September 16, 1975, R[redacted] went to Rosarita Beach where respondent looked at her breast and prescribed an antibiotic, to wit: Erythromycin. No further examination or treatment was conducted or rendered by respondent.

I. On or about September 21, 1975, the aforementioned infection began to drain and R[redacted] called respondent who agreed to see her at his Riverside office on September 22, 1975, at 3 p.m. R[redacted] arrived at respondent's Riverside office at approximately 3:15 p.m. and waited at the aforementioned apartment building, as instructed, until approximately 10 p.m. for respondent to arrive. R[redacted] left at 10 p.m., respondent never having appeared.

/

J. On or about October 1, 1975, R[redacted] saw respondent for the last time at his Point Loma office. She was still suffering from the infection and respondent prescribed more antibiotics.

K. R[redacted]'s infection progressed to the point that her life became endangered, resulting in the surgical removal of the prosthesis from her left breast on or about October 10, 1975. R[redacted] continued to have difficulty with the infection and a second surgery on or about November 7, 1975, resulted in the removal of a sponge which was left in the operative sight during the placement of the left implant by respondent.

L. Respondent's treatment of Patricia R[redacted] was grossly negligent in the following respects:

(1) Respondent's selection of La Gloria Hospital as a surgical and postoperative facility constitutes an extreme departure from the standard of medical care.

(2) Respondent's postoperative unavailability constitutes an extreme departure from the standard of medical care in that respondent should have recognized the possibility that R[redacted] would develop a hematoma which could result in infection, and failed to provide adequate monitoring of the patient's progress.

(3) Respondent knew or should have known that Luis Salas was not a qualified

plastic surgeon and respondent's conduct in permitting Salas to participate in R[redacted]'s surgeries constituted an extreme departure from the standard of medical care.

(4) Respondent's permitting of Salas to participate in R[redacted]'s surgeries contrary to R[redacted]'s announced wishes constitutes an extreme departure from the standard of medical care.

(5) Respondent's performance of the second surgery (face lift) one day following the augmentation mammaplasty, with knowledge of R[redacted]'s physical and emotional condition constitutes inhumane treatment and an extreme departure from the standard of medical care.

9. Pursuant to section 2373, the holder of a physician's and surgeon's certificate is not entitled to practice medicine during the term of a suspension; the Division shall revoke the certificate of a certificate holder who practices in this State during the term of a suspension.

10. Respondent's certificate is subject to revocation pursuant to section 2373 in that he practiced medicine in this State while under suspension, as more particularly alleged hereinafter:

A. Pursuant to disciplinary order No. D-1511 of the Board of Medical Examiners (Exhibit A, attached), respondent's physician's and surgeon's certificate has been suspended at all times since December 1, 1975, and will continue under suspension through November 30, 1976.

/

B. On or about December 14, 1975, respondent conducted a medical examination upon Mary H[redacted] (hereinafter "H[redacted]") at his office in Riverside, California. Respondent had previously performed an augmentation mammaplasty upon H[redacted] on or about September 22, 1975, at Rosarita Beach. On or about December 14, 1975, respondent, following said examination, surgically removed an implant from H[redacted]'s left breast at respondent's Riverside office. Said procedure was performed by respondent alone and with the use of local anesthetic agents.

C. In or about the middle of January, 1975, respondent conducted a medical examination of H[redacted]'s left breast at his Riverside office. Following said examination, respondent prescribed medical treatment for H[redacted] by ordering a member of his staff to apply ointment to H[redacted]'s left breast at said time.

Complainant makes the following allegations as causes for the revocation of respondent's probation:

11. Pursuant to condition No.1 of respondent's probation included in disciplinary order No. D-1511 of the Board of Medical Examiners, respondent was suspended from the practice of medicine for one year and was thereby prohibited from exercising any of the privileges granted to him under his physician's and surgeon's certificate. Said period of suspension commenced on December 1, 1975.

12. Respondent has violated condition No. 1 of said probationary order in that he has practiced in this State, on at least three occasions, while under suspension as set forth in the allegations contained in paragraph 10 hereinabove.

WHEREFORE, complainant prays that the Division of Medical Quality of the Board of Medical Quality Assurance hold a hearing on the matters alleged herein and following said hearing, issue an order:

1. Revoking respondent's physicians and surgeon's certificate;

2. Revoking respondent's probation and reimposing all, or any part of the stayed revocation; and

3. Taking such other action as the Division deems appropriate.

DATED: 7/26/76.

RAYMOND REID
Executive Officer
Board of Medical Quality Assurance
State of California

Complainant

MAL:dt
03573101-
LA76AD0294
7/23/76

REDACTED

BEFORE THE BOARD OF MEDICAL EXAMINERS

STATE OF CALIFORNIA

In the Matter of the Accusation Against:	NO. D-1511
BEN B. THOMPSON, M.D. 1370 Rosecrans San Diego, California Certificate NO. 20A-1023, Respondent.	L-6355

DECISION

The attached Proposed Decision of the District Review Committee II is hereby adopted by the Board of Medical Examiners as its decision in the above-entitled matter.

This decision shall become effective on the 4th (12-1-75) day of August, 1975.

IT IS SO ORDERED this 3rd day of July, 1975.

BOARD OF MEDICAL EXAMINERS
STATE OF CALIFORNIA

By Harry A. Obenhaus

MH

BEFORE THE BOARD OF MEDICAL EXAMINERS

STATE OF CALIFORNIA

In the Matter of the Accusation Against: BEN B. THOMPSON, M.D. 1370 Rosecrans San Diego, California Certificate NO. 20A-1023, Respondent.	NO. D-1511 L-6355

PROPOSED DECISION

This matter came on regularly for hearing before Board of Medical Examiners District Review Committee II, at Los Angeles, California on March 4, 1975, at the hour of 9:00 a.m. The District Review Committee consisted of James W. Moore, M.D., Philip F. Voight, M.D., and Paul D. Yares, M.D., Chairman, with John A. Willd, Hearing Officer with the Office of Administrative Hearings presiding. This matter was heard on March 4, 5, and 6 and April 1, 2, and 3, 1975, at which time the matter was submitted. Mark A. Levin, Deputy Attorney General, appeared on behalf of complainant. The respondent Ben B. Thompson, M.D. appeared in person and was represented by Roger Liljestrom and Michael J. Gill, his attorneys. Oral and documentary evidence was received and the matter was submitted. After due consideration in executive session the District Review Committee makes the following findings of fact:

I

Raymond Reid is the Executive Secretary of the Board of Medical Examiners of the State of California and made the Accusation herein in his official capacity.

II

On July 11, 1945 respondent Ben B. Thompson, M.D., was issued physician and surgeon's certificate number 20A-1023. At all times mentioned herein said license was and now is in full force and effect.

III

Sometime in August 1970 at respondent's office in Riverside respondent utilized the services of Louis Salas and permitted said Louis Salas to perform a rhinoplasty operation on respondent's patient V[redacted] H[redacted] V[redacted] H[redacted] was never advised prior to the actual operation that Louis Salas would perform this procedure.

IV

In February 1971 respondent utilized the services of Louis Salas in performing a second nose surgery and permitted the said Louis Salas to perform nose surgery on respondent's patient V[redacted] H[redacted] Again the patient was never advised that Louis Salas would perform the surgery. However, at this point the patient was aware that Louis Salas had performed the first procedure.

V

On July 19, 1971 in respondent's office respondent utilized the services of Louis Salas and permitted the said Louis Salas to perform a rhinoplasty on respondent's patient P[redacted] J[redacted] The patient P[redacted] J[redacted] was never advised prior to surgery that Louis Salas would perform this procedure.

VI

Louis Salas comes from Mexico. At the time of the operations on V[redacted] H[redacted] and the operation on P[redacted] J[redacted] Louis Salas was not licensed to practice medicine in the State of Calfornia. Respondent was and now is aware that Louis Salas was not licensed to practice medicine in the State of California.

The rhinoplasty performed on V[redacted] H[redacted] described above did not have an acceptable cosmetic result. The nostrils are prominent and unequal in size. The nose has a distorted appearance in part caused by a deviated septum which apparently was not corrected. As a result of the two surgeries it appears that corrective surgery is now virtually impossible for the patient V[redacted] H[redacted]

The rhinoplasty performed on P[redacted] J[redacted] described above resulted in a distortion of that patient's nose. It has a pinched appearance to such an extent that further corrective surgery could not be expected to correct the distortion. Finally, an infection developed or external incisions were made which has resulted in unnecessary scars.

VII

In October 1971 respondent performed a reduction mamaplasty on V[redacted] A[redacted] The results were unacceptable from a cosmetic standpoint in that the breasts were not of the same size, adequate reduction had not been achieved under the circumstances and finally the nipples were located on the top of the patient's breasts rather than at the ends of the breasts. Corrective surgery was required to further reduce the size of the breasts, to make the breasts of uniform size and to relocate the nipples to a more acceptable location.

VIII

On January 19, 1973 respondent performed breast implant surgery in respondent's office on his patient K[redacted] A[redacted]. In this procedure respondent inserted plastic bags which he filled with a saline solution. As the result of the initial surgery the patient's right breast was larger than the left breast. The patient also complained of lumps in her breasts. In March 1973 respondent at his office attempted corrective surgery. Respondent either removed all of the fluid from both implants or he removed the fluid from one implant and removed the second implant and replaced it with a new one. Respondent then refilled the implants with water and again the right breast was larger than the left breast. The patient K[redacted] A[redacted] continued to complain about the unequal size and also that there were lumps in her breasts. On April 16, 1973 the patient returned to respondent's office and respondent injected with a number eighteen needle 50 cc of silicone into the implant of the smaller breast. Respondent assured K[redacted] A[redacted] that the

silicone would seal the puncture to the bag. K A continued to complain about the unequal size of her breasts. There is a conflict in the testimony between respondent and his patient as to whether or not respondent later removed some of the fluid from the larger breast by means of a hyperdermic syringe. Later in May 1973 the patient K A again returned to respondent's office. Respondent was not at his office at this time. Another physician examined K A and did agree that her breasts were not of uniform size. He offered to remove the implants and replace them if the patient would sign a statement releasing that physician from liability. K A overheard this physician comment to a nurse in the office that he had never previously performed this procedure. At this point K A left the office and the implants were ultimately replaced by another physician.

IX

Respondent is currently [redacted] years of age. He is married and is responsible for the support of a stepson. In 1941 he received his degree in Osteopathic Medicine at Los Angeles, California. He interned at Los Angeles General Hospital and began general practice sometime in 1942. He assisted various general surgeons and took several courses of instruction at U.C.L.A. Medical School and at the University of California Medical School at Berkeley. In 1956 he began a preceptorship training program in general surgery and ultimately became Board eligible in general surgery. He was not certified by the Board of Osteopathic Examiners in general surgery, however, because at this time he elected to use the designation M.D. In 1963 respondent became interested in plastic surgery and since that time he has attended various educational programs in that field held in Vienna, Toronto and Buenos Aires. For the past several years respondent has also attended the annual seminars put on by the American College of Plastic and Reconstructive Surgeons. These seminars are usually of

six days duration and include lectures, discussion groups and demonstrations.

Respondent was very active in raising funds to establish Noelwood Hospital in Riverside County. He has in the past served on several committees of this hospital, and he has also been on the staff of Ontario Community Hospital and Mount Helix Hospital in San Diego. Respondent has experienced some problem with his malpractice insurance and as a result he is not currently on the staff of Noelwood Hospital.

X

Commencing in approximately 1965 respondent began to specialize more and more in the field of plastic surgery. By the end of 1969 respondent had restricted his practice almost exclusively to the field of plastic surgery. Respondent has performed virtually all of his plastic surgery procedures in his office. Normally the surgical area is scrubbed for about one minute and the patient is then draped. A local anesthetic is administered and then sodium pentothal may be administered. Usually respondent is the only physician in attendance. However, he is assisted by his nurse. The patient is then taken to a recovery room. While the precise number of surgical procedures performed by respondent could not be resolved at the hearing the total number of surgical procedures completed by respondent is quite large and respondent does maintain a very heavy schedule of surgeries. Respondent will operate from approximately 7 a.m. until 6 p.m. and beyond. On many occasions respondent has operated until 11 p.m. Respondent maintains this level of surgeries at least two and perhaps three days a week. When necessary respondent performs surgeries on Saturdays. Respondent manages his post-operative care and pre-operative conferences by seeing patients in between his scheduled surgeries while his nurses prepare the next patient. Respondent performs a large number of augmentation mamaplastys, several reduction mamaplastys, as well as rhinoplastys. In addition respondent does numerous facelifts as well as other cosmetic surgery

involving the ear and chin.

With respect to Louis Salas respondent met this individual while attending a seminar in Toronto. In respondent's opinion Louis Salas is a very qualified individual even though he is not licensed to practice in California. While respondent did know that Louis Salas was not licensed to practice in this state he had no idea that it was improper for him to permit Louis Salas to perform this surgery. Respondent does point out that out of state surgeons are permitted to operate at various hospitals and these individuals also give demonstrations at various seminars. Apparently Louis Salas was visiting the offices of other physicians and respondent assumed that there was nothing improper in having Louis Salas assist respondent in his surgeries. Actually respondent is of the opinion that Louis Salas is more experienced in the field of plastic surgery than is respondent. With respect to the first rhinoplasty performed on V[redacted] H[redacted] and the rhinoplasty performed on R[redacted] J[redacted] respondent actually intended to perform the surgical procedures and to receive assistance and consultations from Louis Salas. As respondent and Louis Salas made their examination in each instance Louis Salas simply proceeded to perform the surgery without any instruction or direction to do so. The second procedure for V[redacted] H[redacted] was also suggested by Louis Salas and it was intended that Louis Salas perform this surgery. Respondent does conceded that the patients R[redacted] J[redacted] and V[redacted] H[redacted] were not advised that Louis Salas would perform the particular surgery. It is respondent's position that as the attending physician he should be able to decide who will perform such procedures and he also urges that the patients made no objection when Dr. Salas commenced the operation. It must be noted, however, that one of these patients was unconscious at the time the surgery commenced and even where the sedated patient is conscious such a patient could not reasonably be expected to take issue with her surgeon when she is laying on the operating table.

XI

With respect to the patient K[redacted] A[redacted], it is first observed that the respondent did not become aware of that patient's

history of adverse reaction to Demerol until the patient was being prepared for surgery. There are several other factors that disturb the District Review Committee. In addition to unequal size of her breasts the patient was concerned about lumps which she could feel in her breasts. Respondent made various attempts to eliminate these lumps or folds in the insert but he never reassured a worried patient that such folds are common in cases of this sort and should cause no concern. Respondent and his patient K[redacted] A[redacted] now disagree as to which breast was the larger and respondent's medical records give no assistance in this regard. Respondent and his patient also disagree as to whether or not an insert was in fact removed and replaced or whether the insert was simply refilled. The respondent himself is somewhat unsure on this point and no information can be obtained from his medical records. The matter of gravest concern, however, is the fact that respondent attempted to equalize the breast size by inserting 50 cc of silicone directly into the bag containing a saline solution by means of a hyperdermic syringe. Respondent came to the rather doubtful conclusion that the silicone would seal the puncture in a bag where there was already some suspicion that the plastic bag was leaking. The committee finds no reasonable basis for respondent's conclusion in this regard. It is the opinion of the Committee that respondent did not understand the significance of the folds or lumps which appeared and finally he did expose his patient unnecessarily to a risk of infection. He also advanced a procedure where there was no reasonable likelihood that it would correct the underlying problem.

XII

With the respect to the patient V[redacted] A[redacted] it is quite obvious that respondent did not achieve breasts of equal size. The Review Committee is aware that the breasts were not equal in size prior to the procedure. Apparently, however, respondent failed to carefully study this problem. When the surgery was completed the breasts were quite unequal in size, the breasts were still too

large and the nipples were obviously improperly located. Respondent explains the nipple location by claiming that the fatty tissue of the breast migrated downward from the position originally anticipated. The patient, however, complained about the nipple location immediately following surgery. Respondent in the exercise of proper care would have avoided the problems which did develop. There is in this proceeding a dispute between respondent and his patient V[redacted] A[redacted] as to whether or not respondent offered to perform further corrective surgery. This claim is denied by the patient. It is respondent's position that this corrective procedure would be a rather simple matter which he would have undertaken if the patient desired it. In this instance the Committee accepts the version advanced by the patient. This patient came to respondent in an effort to correct disturbing problems which she had because of her very large breasts. The reduction in size was rather small and the disparity in size was more pronounced. It is most likely that the patient would continue to want this condition corrected. Respondent's contention that the corrective procedure would be a rather simple matter is subject to very serious doubt. The plastic surgeon who ultimately performed the corrective surgery is a qualified and capable individual. He was reluctant to perform this surgery and he did so only after considerable thought and a careful examination. He did carefully explain to V[redacted] A[redacted] that there were risks involved and he required that she sign a specially prepared waiver.

XIII

Respondent has been most deficient in his obligation to maintain suitable medical records. Any operative notes are virtually if not actually nonexistent. Very significant steps respondent claims to have taken in the treatment of his patients do not exist in any record. Preoperative and post-operative photographs which respondent claims to take in every instance are missing from the medical files. There is nothing in his medical records which suggest

any patient complaint.

* * * * *

Pursuant to the foregoing findings of fact, the District Review Committee II makes the following determination of issues:

I

Respondent is guilty of unprofessional conduct as defined by Section 2392 of the Business and Professions Code in that on at least three occasions he has aided and abetted an unlicensed individual to practice medicine and surgery in the State of California.

II

Respondent is guilty of unprofessional conduct as defined in Sections 2361(b) and 2361(c) of the Business and Professions Code in that respondent has practiced medicine in a grossly negligent and in a grossly incompetent manner. Examples of such conduct include: Respondent's permitting an unlicensed individual to operate upon respondent's patients, the permitting of another individual to take over an operation respondent was to perform and the failure to advise respondent's patients prior to surgery that another individual would perform the procedure. Respondent was either grossly incompetent or grossly negligent with respect to the surgery he performed on V[redacted] A[redacted]. Respondent had not seen this patient for a period of some months prior to the day of surgery. Careful presurgical planning could well have assisted respondent to obtain a better result. With respect to patient K[redacted] A[redacted] respondent did demonstrate negligence in his original procedure. He was grossly incompetent, however, in failing to recognize that folds or lumps are rather common result of this procedure. He also demonstrated gross incompetence by puncturing the bag containing the saline solution with a needle. Under these circumstances it was a near certainty that the bag would leak. By injecting a silicone solution

in this manner respondent did expose his patient to possible future complications.

This respondent has been guilty of some highly disturbing conduct. He does, however, have an acceptable level of skill in some areas and if he would exercise appropriate personal restraint he does possess the potential to serve a public need with safety. It is the hope and expectation that this respondent will accept the penalty imposed herein as a most serious warning with respect to his future practice.

* * * * *

WHEREFORE, DISTRICT REVIEW COMMITTEE II makes the following order:

1. The physician's and surgeon's certificate number 20A-1023 heretofore issued to respondent Ben B. Thompson is hereby revoked, provided, however said revocation is stayed for a period of six years and respondent is placed on probation to the Board of Medical Examiners upon the following terms and conditions.

(1) Respondent's license shall be suspended for a period of one year from the effective date of this decision and during said one year suspension respondent shall not exercise any of the privileges granted to him under his certificate.

(2) Upon the reinstatment of respondent's certificate and during the remaining five year period of his probation respondent shall perform surgeries only in a hospital which has been approved by the California Medical Association, Joint Commission on Accredition of Hospitals (JCAH), and which is approved by the Board of Medical Examiners. Respondent shall advise the Board in advance of those hospitals where respondent seeks to perform surgery. The Board shall retain the right to either approve or disapprove such hospitals.

(3) Respondent shall obey the laws of the United States, the State of California and its political subdivisions and he shall comply with all of the rules and regulations of the Board of Medical Examiners.

(4) Respondent shall submit quarterly affidavits to the Board attesting to the fact that he has complied with the conditions of probation herein set forth and providing the Board with any further information with respect to respondent's practice as the Board may require.

(5) Respondent shall provide the Board with such information with respect to respondent's medical practice from time to time as the Board may require and respondent shall cooperate with any agent of the Board in the Board's efforts to supervise respondent's probation.

(6) Respondent shall report in person to the Board of Medical Examiners annually at its regularly scheduled meeting held in Los Angeles, California. Respondent shall so report at the first such Board meeting following the effective date of this decision or as he may be directed by the Board.

Upon full compliance with all of the conditions above set forth and at the termination of respondent's probationary period respondent's license shall be fully restored provided, however, should respondent fail to comply with any of the above terms or conditions of his probation then the Board of Medical Examiners after providing respondent with notice and with an opportunity to be heard may set aside the stay and reimpose the order of revocation or take such other action as the Board deems just and reasonable in its discretion.

Paul D. Yates M.D.

PAUL D. YATES, M.D., Chairman
Board of Medical Examiners
District Review Committee II

JAW:mh

REDACTED

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Attorneys for Complainant

BEFORE THE DIVISION OF MEDICAL QUALITY

BOARD OF MEDICAL QUALITY ASSURANCE

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against: BEN B. THOMPSON, M.D. Physician's and Surgeon's Certificate No. 20A-1023, Respondent.	NO. D-1841 AMENDED AND SUPPLEMENTAL ACCUSATION AND PETITION TO REVOKE PROBATION

Complainant, RAYMOND M. REID, alleges as further cause for disciplinary action pursuant to this Amended and Supplemental Accusation against the above named and captioned respondent, as follows:

13. Incompetence constitutes unprofessional conduct pursuant to section 2361(c) of the Business and Professions Code.

14. Respondent is guilty of unprofessional conduct within the meaning of section 2361(c) in that he provided incompetent medical treatment to Patricia R[redacted] in August and September of 1975, as more particularly alleged hereinafter:

A. Paragraph 8A through K is incorporated herein by reference as if fully set forth hereat.

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B. Respondent's treatment of Patricia R[redacted] was incompetent in the following respects:

(1) Respondent's selection of La Gloria Hospital as a surgical and post-operative facility constitutes incompetence in the practice of medicine.

(2) Respondent's post-operative unavailability constitutes incompetence in the practice of medicine in that respondent should have recognized the possibility that R[redacted] would develop a hematoma which could result in infection, and failed to provide adequate monitoring of the patient's progress.

(3) Respondent knew or should have known that Luis Salas was not a qualified plastic surgeon and respondent's conduct in permitting Salas to participate in R[redacted]'s surgeries constitutes incompetence in the practice of medicine.

(4) Respondent's permitting of Salas to participate in R[redacted]'s surgeries contrary to R[redacted]'s announced wishes constitutes incompetence in the practice of medicine.

(5) Respondent's performance of the second surgery (face lift) one day following the augmentation mammaplasty, with knowledge of R[redacted]'s physical and emotional condition constitutes inhumane treatment and incompetence in the practice of medicine.

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WHEREFORE, complainant prays that the Division of Medical Quality of the Board of Medical Quality Assurance hold a hearing on the matters alleged herein and following said hearing, issue an order:

1. Suspending or revoking respondent's physician's and surgeon's certificate; and

2. Taking such other and further actions as the Division deems appropriate.

DATED: 9/7/76.

RAYMOND M. REID
Executive Officer
Board of Medical Quality Assurance
State of California

Complainant

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